I. Annual Rate Recalculation

1. Primary Payment Component

Rates for the primary patient care component will be rebased annually. Two sources of provider-supplied data will be used in this rate rebasing:

- An annual nursing wage and salary survey that the Department will conduct of all Medicaid-participating nursing facilities in Delaware.

- Nursing home cost report data on nurses' fringe benefits and training costs.

Median wages will be redetermined annually from the wage and salary survey, and the standard nurse time factors will be applied for each patient classification. The cost report and wage and salary survey will be for the previous year ending June 30.

2. Non-Primary Payment Components

The payment caps for the secondary, support, and administrative components will be rebased every fourth year using the computation methods specified in Section E above. For the interim periods between rebasing, the payment caps will be inflated annually based on reasonable inflation estimates as published by the Department. Facility-specific payment rates for these cost centers shall then be calculated using these inflated caps and cost report data from the most recently available cost reporting period.

The capital floor and ceiling will be rebased annually.

3. Inflation Adjustment

Per diem caps for primary, secondary, support and administrative cost centers will be adjusted each year by inflation indices. The inflation indices are obtained from the Department of Economics of the University of Delaware and include both regional and national health care-specific economic trends. The inflation forecast is based on the U.S. Consumer Price Indexed. Factors reviewed on the demand side include recent growth rates in the money supply, employment, and business and government debt, as well as the state of the business cycle. Current capacity utilization rates and new capital spending plans, production delivery delays, employment to population ratios, wages, and trends in energy, housing, and food are studies on the supply side. The forecast is also confirmed by reviewing the Consumer Estimates and Columbia University Leading Index of Inflation, interest

rates in the futures markets, the Commodity Research Bureau's Index of Futures Prices, and the trade weighted price of the dollar.

The inflation factors are applied to the actual nursing wage rates to compensate for the annual inflation in nursing costs. This adjustment is made before the nurse training and benefits are added and the wages are multiplied by the standard nurse time factors.

Cost center caps are used to set an upper limit on the amount a provider will be reimbursed for the costs in the secondary, support, and administrative cost centers. Initially, these caps are computed by determining the median value of the provider's actual daily costs, then adjusting upwardly according to the particular cost center. The Secondary cost center cap is 115% of the provider group median, and Administrative costs are capped at 105% of the median. Delaware Medicaid will recalculate non-primary cost center caps every three years. In interim rate years, these cost center caps will not be recomputed. Instead, cost center caps will be adjusted by inflation factors. The inflation index provided by the University of Delaware will be applied to the current cap in each cost center in each provider group to establish the new cap. The actual reported costs will be compared to the cap. Facilities with costs above the cap will receive the amount of the cap.

J. Medicare Aggregate Upper Limitations

The State of Delaware assures HCFA that in no case shall aggregate payments made under this plan, inclusive of DEFRA capital limitations, exceed the amount that would have been paid under Medicare principles of reimbursement. As a result of a change of ownership, on or after July 18, 1984, the State will not increase payments to providers for depreciation, interest on capital and return on equity, in the aggregate, more than the amount that would be recognized under section 1861(v)(1)(0) of the Social Security Act. Average projected rates of payment shall be tested against such limitations. In the event that average payment rates exceed such limitations, rates shall be reduced for those facilities exceeding Medicare principles as applied to all nursing facilities.

III. Rate Determination ICF/MR and ICF/IMD Facilities

Delaware will recalculate the prospective per diem rates for ICF/MRs and ICF/IMDs annually for the reimbursement year or October through September 30. ICF/MR and ICF/IMD facilities shall be reimbursed actual total per diem costs determined prospectively up to a ceiling. The ceiling is set at the 75th percentile of the distribution of costs of the facilities in each class. There are four (4) classes of facilities which are:

1. Public ICF/MR facilities of 8 beds or less.
2. Public ICF/MR facilities of greater than 8 beds.
3. Private ICF/MR facilities of 60 beds or less.
4. Public ICF/IMD facilities.

An inflation factor (as described in II.H.3 above) will be applied to prior year's costs to determine the current year's rate.

IV. Rate Reconsideration

A. Primary Rate Component

Long-term care providers shall have the right to request a rate reconsideration for alleged patient misclassification relating to the Department's assignment of the class. Conditions for reconsideration are specified in the Department's nursing home appeals process as specified in the long-term care provider manual.

1. Exclusions from Reconsideration

Specifically excluded from patient class reconsiderations are:

- Changes in patient status between regular patient class reviews.
- Patient classification determinations, unless the loss of revenues for a month's period of alleged misclassification equals ten percent or more of the facility's Medicaid revenues in that month.

2. Procedures for Filing

Facilities shall submit requests for reconsiderations within sixty days after patient classifications are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as required by the Department.

3. Patient Reclassifications

Any reclassification resulting from the reconsideration process will become effective on the first day of the month following such reclassification.

B. Non-Primary Rate Components

Long-term care providers shall have the right to request a rate reconsideration for any alleged Department miscalculation of one or more non-primary payment rates. Miscalculation is defined as incorrect computation of payment rates from provider supplied data in annual cost reports.

1. Exclusions from Reconsideration

Specifically excluded from rate consideration are:

- Department classification of cost items into payment centers.
- Peer-group rate ceilings.
- Department inflation adjustments.
- Capital floor and ceiling rate percentiles.

2. Procedures for Filing

Rate reconsiderations shall be submitted within sixty days after payment rate schedules are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as requested by the Department.

3. Rate Adjustments

Any rate adjustments resulting from the reconsideration process will take place on the first day of the month following such adjustment. Rate adjustments resulting from this provision will only affect the facility that had rate miscalculations. Payment ceilings and incentive amounts for other facilities in a peer group will not be altered by these adjustments.

V. Reimbursement for Super Skilled Care

A higher rate will be paid for individuals who need a greater level of skilled care than that which is currently reimbursed in Delaware nursing facilities. For patients in the Super Skilled program prior to 4/1/93, the rate will be determined as follows:

A summary of each individual who qualified under the Medicaid program's criteria for a "Super Skilled" level of care will be sent to local nursing facilities which have expressed

an interest in providing this level of care. They will be asked to submit bids, within a specific time frame, for their per diem charge for caring for the individual. The Medicaid program will review the bids and select the one that most meets the needs of the patient at the lowest cost.

Effective 4/1/93, all new patients who would have formerly been placed in a super skilled level will be placed in one of the patient class levels and reimbursed as any other client. The Medicaid program will pay outside of the per diem rate for the exceptional costs of their care, such as ventilator equipment and special supplies required.

VI. Reporting and Audit Requirements

A. Reporting

All facilities certified to participate in the Medicaid program are required to maintain cost data and submit cost reports on the form and in the format specified by the Department. Such reports shall be filed annually. Cost reports are due within ninety days of the close of the state fiscal year. All Medicaid participating facilities shall report allowable costs on a state fiscal year basis, which begins on July 1 and ends the following June 30. The allowable costs recognized by Delaware are those defined by Medicare principles.

In addition, all facilities are required to complete and submit an annual nursing wage survey on a form specified by the Department. All facilities must provide nursing wage data for the time periods requested on the survey form.

For patients in the Super Skilled program prior to 4/1/93, annual Super Skilled bids will be considered the cost report for Super Skilled services. The nursing facility cost report must be adjusted to reflect costs associated with care for Super Skilled patients.

Failure to submit timely cost reports or nursing wage surveys within the allowed time periods, when the facility has not been granted an extension by the Department, shall be grounds for suspension from the program. The Department may levy fines for failure to submit timely data as described in Section II.D. of the General Instructions to the Medicaid nursing facility cost report.

B. Audit

The Department shall conduct a field audit of facilities each year in at least 15 percent of participating facilities, in accordance with federal regulation. Both cost reports and the nursing wage surveys will be subject to audit.

Overpayments identified and documented as a result of field audit activities, or other findings made available to the Department, will be recovered. Such overpayments will be accounted for on the Quarterly Report of Expenditures within 60 days of the time the error is found.

Rate revisions resulting from field audit will only affect payments to those facilities that had an identified overpayment. Payment ceilings and incentive payments for other facilities within a peer group will not be altered by these revisions.

C. Desk Review

All cost reports and nursing wage surveys shall be subjected to a desk review annually. Only desk reviewed cost report and nursing wage survey data will be used to calculate rates.

VII. Reimbursement for Out-of-State Facilities

Facilities located outside of Delaware will be paid the lesser of the Medicaid reimbursement rate from the state in which they are located or the highest rate established by Delaware for comparably certified non-state operated facilities as specified above.

VIII. Reimbursement of Ancillary Service for Private Facilities

Oxygen, physical therapy, occupational therapy, and speech therapy will be reimbursed on a fee-for-service basis. The rates for these services are determined by a survey of all enrolled facilities' costs. The costs are then arrayed and a cap set at the median rate. Facilities will be paid the lower of their cost or the cap. The cap will be recomputed every three years based on new surveys.

The Delaware Medicaid Program's nursing home rate calculation, the Patient Index Reimbursement System, complies with requirements found in the Nursing Home Reform Act and all subsequent revisions. A detailed description of the methodology and analysis used in determining the adjustment in payment amount for nursing facilities to take into account the cost of services required to attain or maintain the highest practicable physical, mental and psycho social well-being of each resident eligible for benefits under Title XIX is found in Attachment A.

Attachment A

Annual Nursing Home Assurances

In accordance with 42CFR, Part 447, Subpart C, §447.253, Delaware makes the following findings and assurances:

- Delaware Medicaid pays for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards [42CFR §447.253(b)(1)(i)].

- Except for preadmission screening for individuals with mental illness and mental retardation under 42FR §483.20(f), the methods and standards used to determine long-care facility payment rates take into account the costs of complying with the requirements of 42CFR, Part 483, Subpart B [42CFR 253(b)(1)(iii)(A)].

- The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42CFR §483.30(c) to provide licensed nurses on a 24-hour basis [42CFR §447.253(b)(1)(iii)(B)].

- Delaware establishes procedures under which the data and methodology used in establishing payment rates are made available to the public [42CFR §447.253(b)(1)(iii)(c)].

- The proposed payment rates will not exceed the upper payment limits as specified in 42CFR §447.272 [42CFR §447.253(b)(2)].

- Delaware complies with all the requirements of 42CFR §447.253(d) in determining payments when there has been a sale or transfer of assets of a NF or ICF/MR.

- Delaware Medicaid provides an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates [42CFR §447.253(e)].

- Delaware Medicaid provides for the filing of uniform cost reports by each participating provider [42CFR §447.253(f)].

- Delaware Medicaid provides for periodic audits of the financial and statistical records of participating providers [42CFR §447.253(g)].

- Delaware Medicaid determines that the public notice requirements in 42CFR §447.205 are not applicable since no changes are being made in payment methodology or rates [42CFR §447.253(h)].

- Delaware Medicaid pays for long-term care services using rates determined in accordance with methods and standards in its approved State Plan [42CFR §447.253(i)].

In accordance with 42CFR §447.255, Delaware submits the following information:

- There is no change in payment rates.

- There is no change that will have any short or long term effects on (1) the availability of services on a statewide basis, or (2) the type of care furnished, or (3) the extent of provider participation.

STATE OF DELAWARE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF ECONOMIC SERVICES

STATEMENT OF REIMBURSEMENT

COST FOR SKILLED AND INTERMEDIATE CARE

NURSING FACILITIES

TITLE XIX

INSTRUCTIONS

version: 12/86

TN SP 248 Approval date 9/2/87

Supercedes TN 227 Effective date 7/1/87

STATE OF DELAWARE

STATEMENT OF REIMBURSEMENT COST FOR SKILLED

AND INTERMEDIATE CARE NURSING FACILITIES

TITLE XIX

1. FOR THE PERIOD: TO:

2. NAME OF FACILITY _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

3. Name and telephone number of person to contact in case of questions concerning this report:

NAME:
TITLE:
TELEPHONE NUMBER:

4. TYPE OF ENTITY: (check one only)

A. Corporation _____
B. Individual Proprietorship _____
C. Non-Profit Organization _____
D. Partnership _____
E. State Facility _____
F. Other (Describe) _____

Under penalties of perjury, I declare that I have examined this Statement of Reimbursement Cost, including accompanying schedules, statements and adjustments and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than facility personnel) is based on all information of which preparer has any knowledge.

5. Your signature: _____ Date: _____

Title: _____

6. Preparer's signature: _____ Date: _____

Company or Organization Name: _____

Street address: _____

City, State, Zip Code: _____

version: 12/86

TN SP 248 Approval Date 9/2/87

Supersedes TN SP227 Effective Date 7/1/87